UTAH STATE MEDICAID DUR COMMITTEE
THE AMBER SHEET

Volume 8 **Number 4**
July, 2000

Dr. Lowry Bushnell DUR Board Chairman

Editors: **RaeDell Ashley, R.Ph., Duane Parke, R.Ph.**

An "unofficial" publication of the State Medicaid DUR Board

ATTENTION!!!!

SPECIAL NOTICE ON REIMBURSEMENT

PROVIDERS !!! The United States Department of Justice, et al, has mandated that the most commonly accepted pricing reference for pharmaceuticals, the Average Wholesale Price (AWP), be updated to reflect a true value. Over the years, manufacturers, wholesalers and buying groups have caused the AWP to become hopelessly outdated. State Medicaid agencies all use some form of "AWP - discount + fee" to set the price paid to providers. In Utah the "AWP - discount" part is set at AWP - 12% for pharmacies. For physicians using J-codes, prices are based either at 5% less than Medicare, or AWP - 15%.

The United States Department of Justice, the United States Department of Health and Human Services, the Office of the Inspector General and others have entered the picture along with the National Association of Medicaid Fraud Control Units. The above agencies have undertaken the project of setting a more accurate pricing schedule called "Average Market AWP" or AMAWP. First DataBank, who is caught in the middle, will use the AMAWP as the AWP for the identified drugs. The Justice Department has enlisted six large pharmaceutical wholesalers, including Bergen Brunswig, McKesson, ASD Specialty Healthcare, Florida Infusion, Oncology Supply, Oncology Therapeutics Network and Triad Medical to help determine the real AWP. They have also consulted with three group purchasing organizations: Automated Health Technologies, Oncology Solutions, and Greater New York Hospital Association. Drug products, via the NDC (national drug code) are being repriced at a rate of ~ 400 per batch. Medicaid has received the first 400 prices. It remains to be seen if more products will be rebased. The NDCs and their new "AWP" are listed on the DUR Board web site's "Current Issues" under the name AMAWP. All prices are based on unit of 1ml, 1 dry lyophilized vial, one tablet, 1 kit, etc. The web sight address is: "http://hlunix.ex.state.ut.us/medicaid/dur " Pharmacy reimbursement will be affected as will physician reimbursement for medications given in the office and billed by J-code or Y-code. Since it is in Medicaid's best interest to insure providers do not give medications at a loss, close communication will be necessary to re-set prices that are below cost. Utah Medicaid is taking a cautious approach to this new development. Utah is implementing the new defacto AWP prices at "AWP = EAC" on the first 400 NDCs temporarily. Initially, the discount of 12% (pharmacists) or 15% (physicians) will be suspended on the first 400 products. Remember, this fix may only be temporary.

Your cooperation is requested. Medicaid may request copies of your invoices showing a loss position. All correspondence will be held strictly confidential. If you wish to discuss the program please call drug program managers RaeDell Ashley or Duane Parke at (801) 538-6149 or FAX (801) 583-6099. **********

ATYPICAL ANTIPSYCHOTIC DRUG USE INCREASES!

Expenditures for the four atypical antipsychotic drugs will increase by over one million dollars this fiscal year. A recent drug utilization review for the month of March on the atypical antipsychotics shows that there is considerable price differences between these four agents. Clozapine's side effects cause it to be self limiting. For the other three, Medicaid encourages physicians to use the least costly alternatives whenever possible. Since the four atypicals will cost over ten million dollars this fiscal year, vigilance is necessary. The following table shows utilization patterns for the month of March.

Utilization for March 2000

drug	patients	units	cost	cost/patient
clozapine	296	37,641	$111,012.65	$375.04
olanzapine	1,318	64,008	$393.667.54	$298.69
quetiapine	606	57,569	$136,485.20	$225.22
risperdal	1,399	74,640	$244,250.53	$174.59

total	3,364 net patients	233,858	$885,415.92	Ave. $263.20

An analysis of the data show that 255 of these patients received two or more of the atypicals in March. Whether this is therapeutic duplication or simply switching to a second choice is unknown. Medicaid's criteria set for these four agents does not support therapeutic duplication. These current prices (cost/patient) differ considerably from those listed in the criteria set posted on the DUR Board's web site probably because in practice, the average daily dose has decreased for some of these agents such as risperdal, as practitioners have become more proficient in using them.

The atypicals account for well over 90% of the cost of the therapeutic class H2L, which includes haloperidol and a few other non-phenothiazine antipsychotics. For comparison, H2J, the antidepressants including the SSRIs will also cost more than ten million dollars this year. The atypicals had 3,364 patients in March 2000, the antidepressants in H2J had more than 11,000 patients in March 2000. Although both drug groups are for mental health, clearly more clients are served with the antidepressants.

The number of children ages 19 and under receiving the atypicals agents last March are :

clozapine	olanzapine	quetiapine	risperdal
5	147	120	273

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Atypical Antipsychotics Now Require a Diagnosis!!
Effective July 1, 2000, all prescription for atypical antipsychotics required that the prescriber write the ICD-9 code on the prescription. The pharmacist must enter this code into the diagnosis field on his screen. The code must be at least four digits long, disregarding the decimal. Pharmacists, do not enter the decimal. Acceptable ICD-9 codes are listed in the June Medicaid Information Bulletin (MIB). Pharmacist, do not fill in the blank without consulting with the prescriber. If the prescriber omits the ICD-9 code, please call and obtain it.

A drug utilization review will be completed after six to nine months to evaluate utilization patterns. Accuracy is a must. Codes that are not used or cannot be supported by positive patient outcomes will be dropped from the approved list. *******

((Effective Immediately, use of the Medicaid pre-printed prescription pad for the H-2s and the PPIs (Tagamet® Prilosec®, etc.) is no longer required.

Effective October 1, 2000, Prevacid®, Prilosec® Aciphex® and Protonix® (and any other PPI) will be restricted to 60 tablets per 30 days. *******

FEDERAL UPPER LIMIT (FUL)List - The web sight for the FEDERAL UPPER LIMIT ON DRUGS is: www.hcfa.gov/medicaid/drug10.htm. For practical purposes, FUL = MAC (maximum allowed cost). ********

AGGRENOX® PLACED ON PRIOR APPROVAL ; Aggrenox®, the new formulation of two old components, ASA and dipyridamole, has not been shown to be superior to the sum of its parts. So far, neither has the unique 25mg/200mg-LA formulation been shown to be superior to a combination of any other amounts of the two components. The manufacturer of Aggrenox, Boehringer Ingelheim, currently has a 2nd major study in the works. If that study significantly refutes any of the above, the prior approval will cheerfully be dropped.

The price of the generic components vs. brand is considerably different. One ASA tablet costs Medicaid < 1¢ per tablet; Two dipyridamole 75mg tablets costs Medicaid 15¢; One Aggrenox® costs Medicaid $1.30. Since Aggrenox is dosed twice a day, the difference is $2.60 - $0.32 = $2.28 per day or ~ $68.00 per month.

Single Dispensing Fee Per Month for LTCF!!
Effective July 1, 2000, pharmacies will only receive one fee per drug (same drug/ same strength) per month for clients in nursing homes or other long term care facilities. Programming has just been completed to support this policy. The "one fee per month" policy has been in the manual for years. Schedule II narcotics are exempt. The program is based on a calendar month, not a 30 day period. ********